

# **DELINEATION OF CLINICAL PRIVILEGES - OPHTHALMOLOGY**

*(For use of this form, see AR 40-68; the proponent agency is OTSG.)*

1. NAME OF PROVIDER <i>(Last, First, MI)</i>	2. RANK/GRADE	3. FACILITY
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**INSTRUCTIONS:**

**PROVIDER:** Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures listed, line through and initial any criteria/applications that do not apply. Your signature is required at the end of Section I. Once approved, any revisions or corrections to this list of privileges will require you to submit a new DA Form 5440.

**SUPERVISOR:** Review each category and/or individual privilege coded by the provider and enter the appropriate approval code in the column marked "APPROVED". This serves as your recommendation to the commander who is the approval authority. Your overall recommendation and signature are required in Section II of this form.

PROVIDER CODES	APPROVAL CODES
1 - Fully competent to perform	1 - Approved as fully competent
2 - Modification requested <i>(Justification attached)</i>	2 - Modification required <i>(Justification noted)</i>
3 - Supervision requested	3 - Supervision required
4 - Not requested due to lack of expertise	4 - Not approved, insufficient expertise
5 - Not requested due to lack of facility support	5 - Not approved, insufficient facility support

## **SECTION I - CLINICAL PRIVILEGES**

Requested	Approved		Requested	Approved	
		General Ophthalmology			Pediatric Ophthalmology

### **PROCEDURES**

EYELID			CONJUNCTIVA		
Requested	Approved		Requested	Approved	
		a. Laceration, partial thickness			a. Repair of lacerations
		b. Laceration, full thickness <i>(single or multiple)</i>			b. Removal of tumors
		c. Canalicular lacerations			c. Excision and repair of pterygium
		d. Total eyelid reconstruction -			d. Conjunctival transplantation
		(1) Upper eyelid			e. Conjunctival mucous membrane grafting
		(2) Lower eyelid			f. Cryotherapy
		e. Partial eyelid reconstruction -			g. Lysis of symblepharon
		(1) Upper eyelid			h. Fornix reconstruction
		(2) Lower eyelid			
		f. Canthus reconstruction - medial or lateral			
		g. Skin grafts to eyelids, upper or lower			
		h. Eyelash grafts			
		i. Eyebrow grafts			
		j. Excision of eyelid tumors			
		k. Eyelid incision and drainage <i>(I&amp;D)</i>			
		l. Scar revision - eyelid, brows			
		m. Correction of blepharospasm			
		n. Correction of congenital eyelid deformities			
		o. Dermabrasion			
		p. Repair of -			
		(1) Blepharochalasis			
		(2) Dermatochalasis, upper or lower lid			
		(3) Epicanthus			
		(4) Telecanthus			
		(5) Ectropion, entropion			
		(6) Eyelid malposition			
		(7) Eyelid retraction			
		(8) Brow ptosis			

  

CORNEA		
Requested	Approved	
		a. Lamellar keratoplasty
		b. Penetrating keratoplasty
		c. Repair of lacerations
		d. Tumor excision
		e. Removal of foreign body
		f. Conjunctival flaps
		g. Cauterization procedures
		h. Relaxing incisions
		i. Astigmatism reduction procedures
		j. Keratoprosthesis
		k. Periosteal grafts
		l. Patch grafts

  

LENS		
Requested	Approved	
		a. Extracapsular cataract extraction
		b. Intracapsular cataract extraction
		c. Phaco-emulsification of cataract





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## SECTION II - SUPERVISOR'S RECOMMENDATION

Approval as requested ☐

Approval with Modifications *(Specify below)* ☐

Disapproval *(Specify below)* ☐

COMMENTS

DEPARTMENT/SERVICE CHIEF *(Typed name and title)*

SIGNATURE

DATE (YYYYMMDD)

## SECTION III - CREDENTIALS COMMITTEE RECOMMENDATION

Approval as requested ☐

Approval with Modifications *(Specify below)* ☐

Disapproval *(Specify below)* ☐

COMMENTS

CREDENTIALS COMMITTEE CHAIRPERSON *(Name and rank)*

SIGNATURE

DATE (YYYYMMDD)

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(For use of this form, see AR 40-68; the proponent agency is OTSG.)

INSTRUCTIONS: Evaluation of clinical privileges is based on the provider's demonstrated patient management abilities appropriate to this discipline, and his/her competence to perform the various technical skills and procedures indicated below. All privileges applicable to this provider will be evaluated. For procedures listed, line through and initial any criteria/applications that do not apply. The privilege approval code (see corresponding DA Form 5440) will be entered in the left column titled "CODE" for each category or individual privilege. Those with an approval code of "4" or "5" will be marked "Not Applicable". Any rating that is "Unacceptable" must be explained in SECTION II - "COMMENTS". Comments on this evaluation must be taken into consideration as part of the provider's reappraisal/renewal of clinical privileges and appointment/reappointment to the medical staff.

CODE	CLINICAL PRIVILEGES	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	General Ophthalmology			
	Pediatric Ophthalmology			
	<b>PROCEDURE/SKILL</b>			
	<b>EYELID</b>			
	a. Laceration, partial thickness			
	b. Laceration, full thickness <i>(single or multiple)</i>			
	c. Canalicular lacerations			
	d. Total eyelid reconstruction -			
	(1) Upper eyelid			
	(2) Lower eyelid			
	e. Partial eyelid reconstruction -			
	(1) Upper eyelid			
	(2) Lower eyelid			
	f. Canthus reconstruction - medial or lateral			
	g. Skin grafts to eyelids, upper or lower			
	h. Eyelash grafts			
	i. Eyebrow grafts			
	j. Excision of eyelid tumors			
	k. Eyelid incision and drainage <i>(I&amp;D)</i>			
	l. Scar revision - eyelid, brows			
	m. Correction of blepharospasm			
	n. Correction of congenital eyelid deformities			
	o. Dermabrasion			
	p. Repair of -			
	(1) Blepharochalasis			
	(2) Dermatochalasis, upper or lower lid			
	(3) Epicanthus			
	(4) Telecanthus			
	(5) Ectropion, entropion			
	(6) Eyelid malposition			
	(7) Eyelid retraction			
	(8) Brow ptosis			



CODE	PROCEDURE/SKILL (Continued)	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	<b>CONJUNCTIVA</b>			
	a. Repair of lacerations			
	b. Removal of tumors			
	c. Excision and repair of pterygium			
	d. Conjunctival transplantation			
	e. Conjunctival mucous membrane grafting			
	f. Cryotherapy			
	g. Lysis of symblepharon			
	h. Fornix reconstruction			
	<b>CORNEA</b>			
	a. Lamellar keratoplasty			
	b. Penetrating keratoplasty			
	c. Repair of lacerations			
	d. Tumor excision			
	e. Removal of foreign body			
	f. Conjunctival flaps			
	g. Cauterization procedures			
	h. Relaxing incisions			
	i. Astigmatism reduction procedures			
	j. Keratoprosthesis			
	k. Periosteal grafts			
	l. Patch grafts			
	<b>LENS</b>			
	a. Extracapsular cataract extraction			
	b. Intracapsular cataract extraction			
	c. Phaco-emulsification of cataract			
	d. Discission of lens capsule			
	e. Capsulotomy			
	f. Capsulectomy - partial or complete			
	g. Intraocular lens -			
	(1) Insertion			
	(2) Removal			
	(3) Repositioning			
	h. Lensectomy using vitreous cutting device			
	i. Phako-fragmentation			
	j. Surgical capsulectomy			
	<b>IRIS</b>			
	a. Extracapsular cataract extraction			
	b. Intracapsular cataract extraction			
	c. Phaco-emulsification of cataract			
	d. Discission of lens capsule			
	e. Capsulotomy			

CODE	PROCEDURE/SKILL (Continued)	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	<b>IRIS (Continued)</b>			
	f. Iridoplasty			
	g. Laser iridotomy			
	<b>GLAUCOMA</b>			
	a. Corneoscleral trephination			
	b. Trabeculectomy			
	c. Trabeculotomy			
	d. Goniotomy			
	e. Aspiration of anterior chamber			
	f. Posterior sclerectomy			
	g. Posterior sclerotomy			
	h. Laser trabeculoplasty			
	<b>SCLERA</b>			
	a. Suturing of sclera incisions, lacerations, and ruptures			
	b. Scleral dissection and resection			
	c. Scleral implant			
	d. Scleral explant			
	e. Diathermy of sclera			
	f. Cryopexy of sclera			
	g. Scleral graft			
	<b>OCULAR MUSCLES</b>			
	a. Resection of ocular muscle, fixed			
	b. Resection of ocular muscle, adjustable			
	c. Resection of ocular muscle			
	d. Myectomy of ocular muscle			
	e. Myotomy of ocular muscle			
	f. Tenectomy of ocular muscle			
	g. Tenotomy of ocular muscle			
	h. Tucking of ocular muscle			
	i. Posterior fixation suture of ocular muscle			
	j. Transplantation of ocular muscle			
	<b>ORBIT</b>			
	a. Optic nerve decompression			
	b. Orbitotomy -			
	(1) Lateral			
	(2) Anterior			
	(3) Medial			
	(4) Inferior			
	c. Repair of -			
	(1) Orbital floor fractures			
	(2) Orbital wall fractures			

CODE	PROCEDURE/SKILL <i>(Continued)</i>	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	<b>ORBIT <i>(Continued)</i></b>			
	(3) Orbital rim fractures			
	(4) Trimalar fractures			
	(5) Orbital deformities			
	(6) Exenteration deformity with bone/muscle/dermis-fat grafts			
	d. Fine needle aspiration biopsy <i>(orbit)</i>			
	e. Removal of foreign body <i>(orbit)</i>			
	f. Antral/ethmoid decompression			
	g. Exenteration, with or without skin grafts			
	h. Orbital volume augmentation			
	<b>LACRIMAL SYSTEM</b>			
	a. Biopsy lacrimal gland			
	b. Excision of lacrimal gland tumors			
	c. Dacryocystotomy			
	d. Dacryocystectomy			
	e. Conjunctival dacryocystorhinostomy			
	f. Canalicular dacryocystorhinostomy			
	g. Probing of lacrimal system			
	h. Intubation of lacrimal collecting system			
	i. Correction of punctal malposition			
	j. Repair of lacrimal trauma			
	k. Repair of lacrimal fistula			
	l. Turbinate fracture			
	m. Dacryoadenectomy			
	<b>RETINA</b>			
	a. Cryopexy of retinal holes			
	b. Diathermy of retinal holes			
	c. Intraocular laser photocoagulation			
	d. Slit lamp laser photocoagulation			
	e. Retinal membrane peeling			
	f. Retinal suturing			
	<b>CHOROID</b>			
	a. Cryopexy of choroid			
	b. Diathermy of choroid			
	c. Subretinal fluid drainage			
	d. Intraocular gas injection			
	e. Intraocular medication injections			
	<b>VITREOUS</b>			
	a. Closed vitrectomy			
	b. Open sky vitrectomy			
	c. Aspiration of vitreous			



CODE	PROCEDURE/SKILL <i>(Continued)</i>	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	<b>VITREOUS <i>(Continued)</i></b>			
	d. Intraocular medication injections			
	<b>EYEBALL</b>			
	a. Removal of intra-foreign bodies			
	b. Examination under anesthesia			
	c. Enucleation, with or without implant			
	d. Evisceration, with or without implant, with or without preservation of cornea			
	<b>SOCKET RECONSTRUCTION</b>			
	a. Repair of extruding, extruded implant			
	b. Scleral, facial patch grafting			
	c. Dermis-fat grafting			
	d. Socket augmentation for correction of enophthalmos			
	e. Fornix reconstruction			
	f. Repair eyelid structure weakness			
	g. Mucous membrane grafting			
	h. Repair of contracted sockets			
	i. Socket expansion to correct congenital deformities			
	<b>OTHER</b>			
	a. Cyclo-photocoagulation			
	b. Indirect laser photocoagulation			
<b>SECTION II - COMMENTS</b> <i>(Explain any rating that is "Unacceptable".)</i>				
NAME AND TITLE OF EVALUATOR		SIGNATURE		DATE (YYYYMMDD)